Name:	Phone # (home):
Parent/Guardian:	Phone # (Cell):
Address:	Date of Birth: Age:
City/State/Zip	Emergency Contact:
E-mail	Emergency Phone:
☐ Male ☐ Female	Ethnic Origin: ☐ Black ☐ Hispanic ☐ White ☐ Asian ☐ Other:_____

Do you have any of the following diseases or problems:	**Yes**	**No**
Active Tuberculosis	☐	☐
Persistent cough greater than a 3 week duration	☐	☐
Cough that produces blood	☐	☐
Recently been exposed to anyone with tuberculosis	☐	☐
Active cold sore, lesion of the lip or oral herpes	☐	☐

Medical Information *Please mark (X) your response to indicate the following diseases or medical conditions.*

	Yes	**No**
Are you now under the care of a physician?	☐	☐

Physician Name: _____

Address/City/State/Zip: _____

Phone: _____Fax:_____

Are you in good health?	☐	☐
Any changes with your health within the past year?	☐	☐

If Yes, what condition is being treated?

_____

Have you had a serious illness, surgery, or been hospitalized in the past 5 years?	☐	☐

If Yes, what was the serious illness or problem?

_____

Joint Replacement Do you have an orthopedic total joint (hip, knee, elbow, finger) replacement	☐	☐

Date: _____

If Yes, have you had any complications? _____

Are you taking or scheduled to begin taking medications for Osteoporosis or Paget's disease?	☐	☐
Were you treated or are you presently scheduled to begin treatment with intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐
Do you use recreational drugs?	☐	☐
Do you smoke or consume marijuana/cannabis?	☐	☐
Do you use tobacco (smoking, vape, snuff, chew, bidis)?	☐	☐

If so, how interested are you in stopping?

(Circle one) VERY / SOMEWHAT / NOT INTERESTED

Do you drink alcoholic beverages? Per week? _____	☐	☐

WOMEN ONLY Are you:	**Yes**	**No**
Pregnant?	☐	☐

Number of weeks: _____

Taking birth control pills or hormonal replacement?	☐	☐
Nursing?	☐	☐

Allergies Are you allergic, or had any reaction to:	**Yes**	**No**
Local anesthetics	☐	☐
Aspirin	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa drugs	☐	☐
Codeine or other narcotics	☐	☐
Latex	☐	☐

Other: _____

Medical Information *Please mark (X) your response to indicate the following diseases or medical conditions.*

	Yes	**No**
Artificial/prosthetic heart valve	☐	☐
Congenital heart disease (CHD)	☐	☐
Damaged valves in transplanted heart	☐	☐
Previous infective endocarditis	☐	☐
Cardiovascular disease	☐	☐
Angina/chest pain	☐	☐
Arteriosclerosis	☐	☐
Congestive heart failure	☐	☐
Damaged heart valves	☐	☐
Heart attack	☐	☐
Heart murmur	☐	☐
Low blood pressure	☐	☐
High blood pressure/Hypertension	☐	☐
Mitral valve prolapse	☐	☐
Pacemaker	☐	☐
Rheumatic fever	☐	☐
Rheumatic heart disease	☐	☐
Abnormal bleeding/bleeding disorder/blood thinners	☐	☐
Anemia	☐	☐
Blood transfusion, Date: _____	☐	☐
Hemophilia	☐	☐
AIDS or HIV infection	☐	☐
Arthritis	☐	☐
Autoimmune disease	☐	☐
Rheumatoid arthritis	☐	☐
Systemic lupus erythematous	☐	☐
Asthma	☐	☐
Bronchitis	☐	☐
Emphysema	☐	☐
Cancer/chemotherapy/radiation treatment	☐	☐
Chest pain upon exertion	☐	☐
Diabetes Type I or II	☐	☐
Eating disorder	☐	☐
Malnutrition gastrointestinal disease	☐	☐
G.E. Reflux/persistent heartburn	☐	☐
Ulcers	☐	☐
Thyroid problem	☐	☐
Stroke	☐	☐
Glaucoma	☐	☐
Hepatitis, jaundice or liver disease	☐	☐
Epilepsy, fainting spells or seizures	☐	☐
Neurological disorders	☐	☐
Mental health disorder, Specify: _____	☐	☐
Kidney problems	☐	☐
Osteoporosis	☐	☐
Persistent swollen glands in neck	☐	☐
Sexually transmitted disease	☐	☐
Other health issues or surgery restrictions	☐	☐

Prescription Drugs/Over the Counter Medications/Supplements Currently Taking: ***(if more than 6 medications, inform dental staff)***	
1.	4.
2.	5.
3.	6.

Name	**Signature**	**Printed Name**	**Date**
Client/Guardian			
Staff			